# Menstrual Health, Family Planning and Maternal Health

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Ezulwini Mayors walk in Eswatini, South Africa.

Photo: Gender Links

## Key points

- Despite progress SADC is not on course to achieve some key SDG, SADC Gender Protocol and SADC SRHR strategy targets. Some countries are doing better than others.
- The maternal mortality ratio (MMR) remains high in SADC. The regional average has remained static at 397 deaths per 100 000 deliveries. Only Mauritius and Seychelles have achieved the SDG target of MMR lower than 70 per 100 000 live births.
- Four countries have met the target for Neonatal mortality rate of below 12 per 1000 live births.
- Seven SADC countries have now removed VAT on menstrual products and seven provide free sanitary wear in schools.
- Fewer than half of the population has access to basic handwashing facilities at home. Namibia has the highest coverage (45%), and Lesotho has the lowest (6%).
- Contraceptive prevalence rate (CPR) in the SADC region ranges from 59% in Botswana to a low 17% in Angola. Seven countries meet or exceed the global average of 49%.
- Angola has the highest unmet need for contraception with 38% of women of reproductive age (15-49 years) having a need for family planning not met. Only Zimbabwe is below the global average of 10%.
- Eleven countries in SADC have now included Human Papillomavirus (HPV) in their national vaccination programme, though coverage varies across countries, from 67% in Mauritius and 65% in Tanzania to a low of 13% in Malawi.
- Seven SADC countries have national cervical cancer screening programmes. However, large-scale coverage remains a challenge, ranging from 3% in Mozambique to 52% in South Africa, for women who have ever been screened for cervical cancer.
- Botswana is the only SADC country that has met and exceeded the Abuja commitment of 15% of the state's annual budget for health.
- Only Lesotho spends more than 10% of its GDP on health.

# Introduction

Sexual and reproductive health is an essential aspect of well-being that affects individuals throughout their lives, from infancy to old age. While both women and men have specific health needs in this area, women tend to face more significant challenges due to their primary roles in childbirth and caregiving. Throughout their lives, women require various services that address their reproductive health needs. These include menstrual health and hygiene, access to contraception and family planning, antenatal care, safe delivery services, post-natal support, prevention and treatment of sexually transmitted infections (including HPV), as well as early diagnosis and management of reproductive health issues such as breast and cervical cancer. Addressing these needs is essential for promoting overall health and well-being for women at every stage of life.[1]

Since the International Conference on Population and Development (ICPD) held in 1994, Sexual and Reproductive Health and Rights (SRHR) have been acknowledged as vital to women's human rights and dignity, which are essential for development. Safeguarding sexual and reproductive health is also a human rights issue, and neglecting these matters has far-reaching effects, including influences on infant and child mortality rates as well as HIV prevention and treatment.

At the international level, significant advances have been made. The global contraceptive prevalence rate has increased by 25% worldwide. There has been a sharp decline in adolescent births, and the global maternal mortality rate has also declined. However, the progress has been gradual and inconsistent. Hundreds of millions of women globally are still not utilising modern contraceptives to avoid unintended pregnancies, and the global targets for reducing maternal and neonatal mortality have not been achieved.[2]



Women on the Cape Flats sew reusable pads with the support of New Heritage, a Women Voice and Leadership grantee. Photo: Colleen Lowe Morna

At the regional level, SADC heads of state adopted the SADC SRHR Strategy and Scorecard 2019-2030, aligned with the SDGs. In 2023, SADC released the second milestone scorecard, reflecting progress, stagnation and regression across 20 SRHR indicators. Progress in critical areas such as maternal and neonatal mortality and women's unmet need for contraception has been slow or has regressed. Budget allocations remain stagnant.

This chapter evaluates advances in women's sexual and reproductive health and rights (SRHR) through 18 indicators related to menstrual health, neonatal health, family planning, maternal health, access to water and sanitation, as well as proportion of budget committed to health. The chapter illustrates that the journey toward achieving the targets outlined in the Sustainable Development Goals (SDGs) and the SADC SRHR scorecard is not straightforward, and even when progress is made, there is always a risk of rollback if governments are not alert and fully dedicated to reaching and maintaining these goals. In instances with a decline, it is crucial to investigate and comprehend the reasons behind it and implement new strategies that tackle both ongoing and emerging challenges to the realisation of SRHR.

[1] UNFPA, Sexual and reproductive health, https://www.unfpa.org/sexual-reproductive-health , accessed 4 February 2025
[2] World Health Organization, 2014 International Conference on Population and Development, https://www.unfpa.org/icpd , accessed 10 September 2022

Table 2.1: SRH indicators in 2024

| Indicators | Angola | Botswana | Comoros | DRC | Eswatini | Lesotho | Madagascar | Malawi | Mauritius | Mozambique | Namibia | Seychelles | South Africa | Tanzania | Zambia | Zimbabwe |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Existence of SRHR policies/ guidelines | No | Guide-lines | Yes | No | 2019 Policy | 2008 Policy | 2017 Policy | 2009 Policy | 2007 Policy | 2011 Policy | 2019 Policy | 2012 Policy | 2019 Policy | 2018-22 Guidelines | 2008 Policy | 2010-15 Policy |
| Provision of free menstrual products in schools | No | Yes | No | No | No | Yes | No | No | Yes | No | No | Yes | Yes | No | Yes | Yes |
| Removal of Value Added Tax (VAT) on menstrual products | No | No | No | No | No | Yes | No | Yes | Yes | No | Yes | Yes | Yes | No | No | Yes |
| Access to at least basic sanitation (%)[3] (2017 figures) | 52 | 81 | 36 | 16 | 64 | 50 | 15 | 49 | 95 | 37 | 36 | 100 | 78 | 31 | 36 | 35 |
| Access to basic handwashing facilities[4] | 27 | No data | 16 | 19 | 24 | 6 | 27 | 8 | No data | 12 | 45 | No data | 44 | 48 | 18 | 42 |
| Contraceptive prevalence rate amongst *all women* aged 15-49 (%) any method[5] | 17 | 59 | 21 | 27 | 53 | 52 | 42 | 50 | 44 | 29 | 53 | No data | 52 | 38 | 38 | 51 |
| % women of reproductive age (15-49) with unmet need for family planning[6] | 38 | No data | 19 | 29 | 15 | 18 | 15 | 15 | 13 | 23 | 12 | No data | 21 | 21 | 30 | 8 |
| Females involved in decision-making for contraceptive use amongst women aged 15-49 (%)[7] | 74 | No data | 71 | 85 | 89 | 93 | 93 | 91 | No data | 85 | 83 | No data | 85 | 85 | 87 | 93 |
| Maternal Mortality Ratio (per 100,000 live births)[8] | 239 | 243 | 186 | 547 | 452 | 618 | 408 | 439 | 33 | 452 | 385 | 64 | 86 | 556 | 252 | 462 |
| Antenatal Care Visits (At least one visit) %[9] | 82 | 94 | 95 | 82 | 99 | 91 | 89 | 97 | No data | 87 | 97 | No data | 94 | 90 | 99 | 96 |
| Antenatal Care Visits (At least four visits) %[10] | 61 | 73 | 64 | No data | 74 | 77 | 60 | 51 | No data | 49 | 63 | No data | 76 | 65 | 64 | 72 |
| Births attended by skilled health staff (% of total)[11] | 50 | 100 | 97 | No data | 88 | 87 | 46 | 96 | 100 | 68 | 88 | 100 | 97 | 85 | 80 | 86 |
| Postnatal care coverage mother %[12] | 23 | No data | 91 | No data | 88 | 84 | 55 | 84 | No data | 36 | 69 | No data | 84 | 51 | 70 | 82 |
| Neonatal mortality (per 1,000 live births)[13] | 24 | 18 | 10 | 27 | 20 | 34 | 26 | 27 | 8 | 30 | 20 | 8 | 10 | 24 | 27 | 32 |
| Nursing and midwifery personnel per 10,000 of the population[14] | 13 | 31 | No data | 12 | 31 | No data | No data | 5 | 30 | 5 | 34 | 73 | No data | No data | 22 | 21 |
| Proportion of females who have received the recommended number of doses of the HPV vaccine prior to age 15[15] | N/A | 22 | N/A | No data | No data | 64 | N/A | 13 | 67 | 57 | No data | 62 | 36 | 65 | 39 | 54 |
| Health expenditure as proportion of GDP[16] | 3 | 6 | 6 | 4 | 7 | 10 | 4 | 7 | 6 | 9 | 9 | 5 | 8 | 3 | 7 | 3 |
| % annual budget allocated to health sector[17] | 7 | 19 | 12 | 9 | 11 | 11 | 8 | 10 | 3 | No data | 12 | 5 | 8 | 7 | 8 | 11 |

*Source: Gender Links computations and UNAIDS 2023 data, https://aidsinfo.unaids.org, accessed 25 July 2024*

[3] World Health Organisation data bank, accessed 2 February 2025
[4] https://data.worldbank.org/indicator/SH.STA.HYGN.ZS?end=2020&locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-NA-SC-ZA-TZ-ZM-ZW-MZ&start=2000 accessed 2 February 2025, no new data (2020)
[5] UNFPA, World Population Dashboard, accessed 2 February 2025
[6] SADC SHR scorecard, accessed 2 February 2025
[7] UNFPA, World population dashboard accessed 2 February 2025
[8] SADC SHR scorecard, accessed 2 February 2025
[9] UNICEF, Maternal and Newborn health coverage database, https://data.unicef.org/topic/maternal-health/antenatal-care/ , Data as of November 2024, accessed 2 February 2025
[10] Ibid
[11] Ibid
[12] Ibid
[13] SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/, accessed 2 February 2025
[14] WHO, The Global Health Observatory, https://data.who.int/indicators/i/B54EB15/5C8435F, accessed 3 February 2025
[15] https://immunizationdata.who.int/global/wiise-detail-page/human-papillomavirus-(hpv)-vaccination-coverage?ANTIGEN=15HPVC_F&YEAR=&CODE=, accessed 17 February. 2025.
[16] World Bank, World Development Indicators, accesses 2 February 2025
[17] SADC SHR scorecard, accessed 2 February 2025

SADC launched its second milestone scorecard with 2023 data. We have used data from the scorecard for the following indicators in this chapter:

- Maternal Mortality Ratio (per 100,000 live births).
- Neonatal mortality (per 1,000 live births).
- % women of reproductive age with unmet need for family planning.
- % annual budget allocated to health.

Table 2.1 shows that:

- Seven SADC countries, (up from six in 2022) - Lesotho, Mauritius, Malawi, Namibia, Seychelles, South Africa and Zimbabwe - have now removed VAT on menstrual products. Seven countries provide free sanitary wear in schools - Botswana, Lesotho, Mauritius, Seychelles, South Africa, Zambia and Zimbabwe.
- The regional average of unmet need for family planning in Southern Africa remains high at approximately 15%, which exceeds the global average of 9%. The lowest unmet need is in Zimbabwe, at 8%, while Angola has the highest rate, currently estimated at 38% of women of reproductive age.
- The contraceptive prevalence rate (CPR) for all women aged 15-49 using all methods ranges from 17% in Angola to 59% in Botswana. Seven countries (Botswana, Eswatini, Lesotho, Malawi, Namibia, South Africa and Zimbabwe) are above the global average of 49%.
- Maternal mortality remains high in SADC. The regional average has remained static at 397 deaths per 100 000 deliveries. Just two of 16 SADC countries, Seychelles and Mauritius, have met the SDG target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births. Lesotho has the highest MMR with 618 deaths per 100 000 live births. Seven other countries (DRC, Eswatini, Madagascar, Malawi, Mozambique, Tanzania and Zimbabwe) have more than 400 maternal deaths per 100 000 live births.
- Four SADC countries (Comoros, Seychelles, Mauritius and South Africa) have achieved the SDG target 3.2 of 12 (or fewer) neonatal deaths per 1,000 live births.
- Eleven SADC countries have now included Human Papillomavirus (HPV) in their national vaccination programmes. Coverage varies significantly, from 13% in Malawi to 67% in Mauritius and 65% in Tanzania.
- Botswana is the only SADC country that has met and exceeded the Abuja commitment of 15% of the state's annual budget for health. Mauritius and Seychelles only spend 3 and 5 percent respectively of annual budget on health.
- Only Lesotho spends more than 10% of its GDP on health. Angola, Tanzania and Zimbabwe spend only 3% of their GDP on health.

SADC launched its second milestone scorecard with 2023 data

# SRHR policy and legislative framework

**Article 6.1 (a) of the SADC SRHR Strategy** obliges member states to establish a multi-sector coordinating entity that includes civil society, networks of youth, adolescents and key populations, and development partners, to domesticate, implement, monitor and evaluate their national SRHR strategies.

**SDG 3.7** call on states to integrate reproductive health into national strategies and programmes. Stand-alone policies on SRHR are a marker of political commitment to realising the SRHR of women and girls and the will to domesticate regional, continental, and global SRHR instruments.

The vision of the SADC SRHR strategy 2019-2030 is to "ensure that all people in the SADC region enjoy a healthy sexual and reproductive life, have sustainable access, coverage and quality SRHR services, information and education, and are fully able to realise and exercise their SRH rights, as an integral component of sustainable human development in the SADC region." The strategy is aligned with the SDGs, and aims to achieve ten SRHR outcomes.

# Status of SRHR policies in SADC

Over the last 20 years, 13 of the 16 SADC countries have developed stand-alone SRHR policies or guidelines on SRHR, though many are now outdated. Challenges remain, particularly around policy barriers affecting access to safe contraception which contributes to high rates of unintended pregnancies and unsafe abortions.

Table 2.2: Status of SRHR policies in SADC

| Country | Policies/guidelines | Year |
|---|---|---|
| **SRHR policies** | | |
| Mauritius | National Sexual and Reproductive Health Policy | 2007 |
| Lesotho | National Reproductive Health Policy | 2008 |
| Zambia | National Reproductive Health Policy | 2008 |
| Zimbabwe | National Adolescent Sexual and Reproductive Health Strategy | 2010-2015 |
| Mozambique | National Sexual and Reproductive Health Policy | 2011 |
| Seychelles | Reproductive Health Policy for Seychelles | 2012 |
| Madagascar | Reproductive Health and Family Planning Law | 2017 |
| Eswatini | National Policy on Sexual and Reproductive Health<br>National Health Sector Strategic Plan | 2019 |
| Namibia | National Integrated Sexual Reproductive Health and Rights Policy | 2019 |
| South Africa | National integrated SRHR Policy | 2019 |
| Malawi | National Reproductive Health and Rights Policy, National Youth Friendly Health Services Strategy | 2022 |
| **SRHR guidelines** | | |
| Botswana | Policy guidelines and service standards for sexual and reproductive health, Adolescent Sexual and Reproductive Health Strategy | 2015 |
| Tanzania | SRHR guidelines and National Adolescent Reproductive Health Strategy, National Adolescent Health and Development Strategy, Five-Year Costed Implementation Plan for Family Planning 2018-2022 | 2018 |
| **No dedicated SRHR policy** | | |
| DRC | National Multi-sectoral Strategic Plan for Family Planning | 2014-2020 |
| Angola | Included in the Constitution | 1975 |
| Comoros | National Health Development Plan | 2010-2015 |

*Source: Audit of SRHR policies and laws, Gender Links, additional online research*

Table 2.2 shows that 13 SADC countries have either stand-alone SRHR laws and policies or SRHR guidelines, however, most of these are outdated.

**Africa Centres for Disease Control and Prevention (Africa CDC) Reproductive Health Strategy Priorities 2022-2026**: The African Union Heads of State revised and then endorsed the revised Maputo Plan of Action, 2016 - 2030 at the 27th AU summit in Kigali, Rwanda in 2016. The plan's overall goal is for joint effort between African Governments, civil society, the private sector and development partners for the implemen-

tation of the continental policy framework on SRHR to end preventable maternal, new-born, child and adolescent deaths, expand contraceptive use, reduce levels of unsafe abortion, end child marriage, eradicate harmful traditional practices including female genital mutilation and prevent gender-based violence and ensure access of adolescents and youth to SRH by 2030 in all countries in Africa.[18]

The plan focuses on the following elements of SRHR: Adolescent Sexual and Reproductive Health (ASRH); maternal health and new-born care; safe abortion care; family planning; prevention and management of sexually transmitted infections including HIV; prevention and management of infertility; prevention and management of cancers of the reproductive system; addressing mid-life concerns of men and women; health and development; the reduction of gender-based violence; interpersonal communication and counselling; and health education. The plan is premised on nine action areas: political commitment, leadership and governance; health legislation; health financing/investments; health services strengthening/human resource development; partnerships and collaborations; information and education; accountability/ monitoring and evaluation; investment in the vulnerable and marginalized populations and improved adolescent and youth SRHR.

The Africa CDC recognises that outbreaks of infectious diseases and other public health threats directly and indirectly cripple SRH services

In 2022, the Africa Centres for Disease Control and Prevention (Africa CDC) officially launched its Reproductive Health Strategy Priorities 2022-2026[19]. The Africa CDC was established in 2017 primarily to help Africa to respond effectively to outbreaks of infectious diseases and other public health threats. The Africa CDC recognises that such outbreaks directly and indirectly cripple SRH services, and supporting SRH services during these emergency situations is not prioritised. Countries affected by humanitarian crises disproportionately contribute to global maternal and new-born mortality and morbidity. The overall goal is to improve maternal and reproductive health in Africa and contribute to the reducing the maternal mortality ratio to less than 70 per 100, 000 live births. The Africa CDC has identified five intermediate outcomes:

1. Minimum of 10-15% of country health budget allocated to Reproductive, Maternal, New-born, Child, and Adolescent Health (RMNCAH).
2. Reduction of Adolescent pregnancy rate by 50%.
3. Improved availability and uptake of HPV vaccine for the primary prevention of cervical cancer.
4. Improved availability and use of Heat Stable Carbetocin for the reduction of maternal deaths from post-partum haemorrhage.
5. Proportion of ever-partnered women and girls aged 15-49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months reduced by 50%.

Amongst the strategies that the Africa CDC has identified is supporting member states to develop and implement a sustainable Community Health Worker workforce, and expand community Health Worker capacity to support scale up of interventions in RH priority areas.

[18] African Union, Maputo Plan of Action 2016 - 2030 for the operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights, Addis Ababa. African Union Commission 2016.
[19] Africa CDC. Reproductive Health Strategic Priorities 2022-2026. 2022. Addis Ababa; Africa CDC.
[20] UNICEF Menstrual Hygiene, accessed 2 February 2025

# Menstrual health

UNICEF recognises that every month, nearly two billion people across the world menstruate. The onset of menstruation is a critical phase for adolescents. However, gender inequality, discriminatory social norms, cultural taboos, poverty and lack of basic services like toilets and sanitary products can all cause menstrual health and hygiene needs to go unmet. As a result, millions of girls, women, transgender men and non-binary persons are unable to manage their menstrual cycle in a dignified, healthy way."[20]

Harmful practices and inadequate facilities to help women and girls deal with their periods continue to deny them their rights to health and dignity; limit or exclude them from productive activities such as attending school, going to work and/or participating in sports and community activities. Many girls and young women do not have easy access to a supply of quality sanitary materials. Missing five days of school or of work every month is substantial hence the need to find interventions to assist these girls and young women.




Lesotho Thabo Morena handing out sanitary pads at Mamantso Council in Mafeteng, Lesotho. Photo: Gender Links

# Period poverty

For millions of women and girls, managing menstrual health is challenging due to a lack of access to affordable products, clean water, and adequate sanitation facilities. This lack of resources, often referred to as period poverty, hinders their daily lives, limits opportunities, and affects their rights and freedoms. This causes anxiety and denies girls of dignity and confidence which impacts on many other aspects of their lives.

Period poverty encompasses more than just the cost of menstrual products; it also includes restricted access to the facilities and education necessary for managing menstrual health effectively. In essence, period poverty imposes significant barriers on women and girls - but it does not have to remain this way. Period stigma, the elevated prices of menstrual products, and the shortage of water and sanitation facilities drive period poverty around the world.



## Women and girls use cow dung for sanitary pads in rural Zimbabwe[21]

Africanews reported in 2022 that girls in rural Zimbabwe are compelled to use cow dung for sanitary care as inflation impacts the cost of feminine hygiene products. The Ministry of Women and Youth Affairs states that 67% of girls miss school during their menstrual cycles due to a lack of sanitary products and clean sanitation facilities. Girls with disabilities often end up dropping out of school entirely.

For example, in the rural area of Domboshawa, located 30 km north of Harare, a study by SNV Netherlands Development Organisation found that 72% of girls lack access to commercially available sanitary products.

At an equivalent of US$2 per pack, most of the country's three million girls who menstruate and live below the poverty line find sanitary pads unaffordable. Families are faced with the dilemma of choosing between buying feminine hygiene products and purchasing food, with most opting for food.

One grandmother interviewed expressed, "Sanitary pads are a luxury I cannot afford for my girls," and explained the process involving cow dung.

"I collect the dung, shape it, and allow it to dry to facilitate blood absorption. The girls do not apply the cow dung directly to their skin. I wrap multiple layers of cloth around it to prevent itching when placed on their underwear. Then I demonstrate how to close their private parts to manage the bleeding."

She adds, "The girls experience heavy flows with cycles that generally last six days. We prefer this method since cow dung absorbs a significant amount of blood. Once it's soaked, we dispose of it discreetly by burying it. Our Shona culture forbids men from seeing such items."

In addition to missing school, health professionals warn that these practices can foster the spread of salmonella, E. Coli, and various bacteria that may lead to reproductive health issues.

Although the government of Zimbabwe has attempted to alleviate the situation by eliminating taxes on all sanitary products, period poverty is worsened by inflation, which exceeds 191%, according to the Zimbabwe National Statistics Agency.

*Source: Africanews*

A range of civil society players, including NGOs, CBOs as well as the private sector, are joining efforts to make safe sanitary wear available to poor girls. This includes reusable pads and menstrual cups. There are also government efforts to make sanitary wear more available as well as to make bud-getary support available for schools to provide sanitary wear.

Removing value-added tax (VAT) is an important first step towards providing affordable menstrual products and governments can show their commitment to addressing women's menstrual health needs by scrapping VAT on sanitary products. There are a growing number of countries in the SADC region that have removed VAT on sanitary products. There are also countries that are making budgetary support available for schools to provide sanitary wear to girls in poor areas.

Providing free sanitary products to school girls, particularly in rural areas will improve educational performance and advance their overall health.

[21] Africanews, https://www.africanews.com/2022/07/11/zimbabwe-girls-resort-to-cow-dung-for-sanitary-pads/ accessed 11 February 2025

Table 2.3: VAT exempted and free menstrual products in SADC

| Country | VAT on sanitary wear exempted | Free sanitary wear in schools[22] |
|---|---|---|
| Mauritius | Yes (2017)[23] | Yes (2018)[24] |
| Lesotho | Yes (2019)[25] | Yes (2021)[26] - Motion passed but implementation lacking |
| South Africa | Yes (2019)[27] | Yes (2019)[28] |
| Zimbabwe | Yes (2020)[29] | Yes (2020)[30] |
| Namibia | Yes (2021)[31] | No |
| Seychelles | Yes (2020)[32] | Yes (2022)[33] |
| Zambia | No | Yes (2019)[34] |
| Botswana | No | Yes (2017)[35] |
| Malawi | Yes (2022)[36] | No |
| Angola | No | No |
| Comoros | No | No |
| DRC | No | No |
| Eswatini | No | No |
| Madagascar | No | No |
| Mozambique | No | No |
| Tanzania | No, removed 2018, reinstated 2019 | No |

*Source: Constructed by Gender Links from sources in footnotes*

Table 2.3 shows that seven SADC countries (Lesotho, Mauritius, Namibia, Malawi, Seychelles, South Africa, and Zimbabwe) have removed VAT on menstrual products. Malawi is the latest country to do so. Seven countries (Mauritius, Lesotho, Seychelles, South Africa, Zimbabwe, Zambia, and Botswana) also provide free sanitary wear in schools.



Piggs Peak councillor, Sbongile Magagula, distributing sanitary pads to students in Eswatini. Photo: Thandokhule Dlamini

[22] Largely of rural schools and indigent populations
[23] https://borgenproject.org/period-poverty-in-mauritius/, accessed 2 February 2025
[24] Ibid
[25] https://borgenproject.org/period-poverty-in-lesotho/ accessed 2 February 2025
[26] Ibid
[27] https://www.globalcitizen.org/en/content/south-africa-sanitary-pads-tax-lifted/ accessed 2 February 2025
[28] https://www.gov.za/news/media-statements/department-women-menstrual-hygiene-day-28-may-2019 accessed 2 February 2025
[29] BDO. Latest VAT and customs developments in Zimbabwe. Indirect Tax News - February 2020. https://www.bdo.global/en-gb/microsites/tax-newsletters/indirect-tax-news/issue-1-2020/zimbabwe-latest-vat-and-customs-developments-in-zimbabwe/ accessed 2 February 2022
[30] Fair Planet. Empowering Lesotho's girls: The fight against period poverty. https://www.fairplanet.org/story/zimbabwe-free-sanitary-wear-program-for-rural-schoolgirls/ accessed 2 February 2025
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[32] Pointe, Elsie. Six sanitary and hygiene products join essential commodities list, 30 May 2020 https://www.nation.sc/articles/4826/six-sanitary-and-hygiene-products-join-essential-commodities-list accessed 2 February 2025
[33] State House Office of the President of the Republic of Seychelles. Seychelles successfully launches national programme to provide free access to sanitary products for all school girls. January 13, 2022. https://www.zawya.com/en/press-release/seychelles-successfully-launches-national-programme-to-provide-free-access-to-sanitary-products-for-all-school-fripfpki accessed 2 February 2025
[34] Jere, J. Focus on Menstrual Health Keeps Zambian Girls in School October 17, 2019. https://www.voanews.com/a/africa_focus-menstrual-health-keeps-zambian-girls-school/6177759.html accessed 2 February 2025
[35] Shick, A. The fight against period poverty in Botswana, August 4, 2022. https://borgenproject.org/period-poverty-in-botswana/ accessed 2 February 2025
[36] Emojong. T. MHH Country Spotlight: Malawi. March 30, 2022. https://www.afripads.com/blog/mhh-country-spotlight-malawi/ accessed 2 February 2025

## South Africa: Local community advocacy

The Organisation for Young Women's Dignity (TOFYWD), a Voice and Choice Southern Africa grantee, has worked with local government to raise awareness on menstrual health and hygiene and address Gender-Based Violence (GBV).

TOFYWD held an Annual Women's Day Soccer Tournament in collaboration with the City of Johannesburg Department of Sport and Recreation, reaching 164 individuals with educational sessions and sanitary pad distribution. They have conducted Menstrual health and hygiene education programmes at two secondary schools, reaching over 1,400 adolescent girls and young women with information and sanitary pad distribution.

TOFWYD has successfully engaged men and boys by including a male influencer as a speaker on menstrual health. His role has been instrumental in reducing the stigma surrounding menstruation, emphasising that these topics concern everyone, not just women. This shift has fostered a more supportive and open environment for discussing menstrual health issues within the community.

Additionally, the male influencer's active participation in discussions on GBV has helped challenge traditional gender stereotypes. By advocating for more balanced gender roles, his engagement has broadened the scope of the project's discussions, fostering an inclusive understanding of gender issues.

The project has successfully expanded its audience to include influential community leaders, such as the local police Commissioner, who had not previously been involved. Their participation has enhanced the project's visibility and brought added support and credibility.

This impact is evidenced by a noticeable increase in community awareness and understanding of menstrual health and GBV, reflected in the positive feedback received and increased requests for information and resources. The programme has reached 1,467 participants across various locations. This outreach highlights the growing community awareness and demand for ongoing education and support on these critical issues.



Beneficiaries of dignity packs and Menstrual Hygiene Education, TOFYWD, .
Credit: Farai Nyamazana

*Source: TOFYWD report to Gender Links*

# Period stigma

Period stigma, which refers to the discrimination faced by people who menstruate, encompasses various forms of prejudice. This can include lack of access to sanitary supplies and verbal shaming, where menstruating individuals are labelled as "dirty" or "unclean." Such stigma can significantly diminish the quality of life for those affected.

The spectrum of discrimination can manifest in several insidious ways. This might begin with seemingly innocuous jokes, which, while intended to be humorous, often draw from outdated stereotypes and serve to belittle the experiences of those who menstruate. Such comments can reinforce societal norms that trivialise menstrual experiences, making it more challenging for

individuals to discuss their needs openly. Moreover, the perpetuation of unfounded beliefs contributes significantly to this discrimination. For example, if someone displays emotional sensitivity, sharpness, or assertiveness during their menstrual cycle, they may be unfairly accused of having "PMS" (premenstrual syndrome). This label reduces a person's complex emotions and behaviours to mere hormonal fluctuations, dismissing the legitimacy of their feelings. As a result, such accusations not only undermine the individual's emotional experience but also perpetuate a harmful stigma that surrounds menstruation, making it difficult for society to acknowledge and support the realities of those who menstruate.

Addressing period stigma requires normalising menstruation, including discussing periods openly and without shame and putting in place school and workplace policies that are explicit about women not being separated or discriminated against during their period.



## Zimbabwe: Involving men and boys in destigmatising menstrual health

Ree Inspiration for Girl-child Empowerment (RIGE), A Voice and Choice Southern Africa Grantee, conducted programmes encouraging men to promote women's access to SRHR services and products. Activities also included engagement of duty bearers and partners that support provision of SRHR services in Bindura rural ward 10, in central Zimbabwe. The background was that in Bindura rural - ward 10, young women faced limited access to sexual and reproductive health (SRH) services due to cultural barriers, lack of support from men, and insufficient knowledge about these services. There are no platforms for women to freely discuss SRHR issues. Additionally, officials from the Ministry of Health and Child Care and other partners are unaware of the SRHR challenges affecting girls and women in this area. Men in ward 10 are also unaware of their crucial roles in supporting women's access to SRHR.




Rige menstrual health programme. Photo: Gender Links

Through speak-out sessions on access to SRHR services and products, father-daughter dialogues on menstrual health (online), menstrual health dialogues with men, and a menstrual health advocacy online campaign, RIGE managed to draw men into SRHR matters concerning women. Through this project, RIGE facilitated good rapport between women in Bindura ward 10, duty bearers, and SRHR service providers. It established male gender champions who are confident about encouraging fellow men to support women's access to SRHR services and products.

*Source: RIGE report to Gender Links*

# Sanitation and hygiene

**Article 26 (c) SADC Gender Protocol**: Ensure the provision of hygiene and sanitary facilities and nutritional needs of women, including women in prison.

**SDG 6.2**: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.

The Southern African region has huge gaps in access to basic water and sanitation services. According to the United Nations Children's Fund (UNICEF), more than 70 per cent of the population in Eastern and Southern Africa (340 million people) have no access to basic sanitation services.[37]

Access to safe water, sanitation, and hygiene is a fundamental human right and essential for individual health, welfare, and the economic and social development of communities and nations. However, millions of people around the world still lack these basic services. Women are particularly affected, as they are often primarily responsible for collecting water and managing household hygiene. Additionally, women face significant challenges due to inadequate sanitation facilities, mainly because of their reproductive roles and the unique WASH-related needs that arise throughout their lives.

Poor access to WASH facilities also increases women and girls' vulnerability to violence.[38] Harassment, abuse, rape and other forms of violence are very real threats when travelling long distances to access water or latrines or having to use unsafe public facilities.



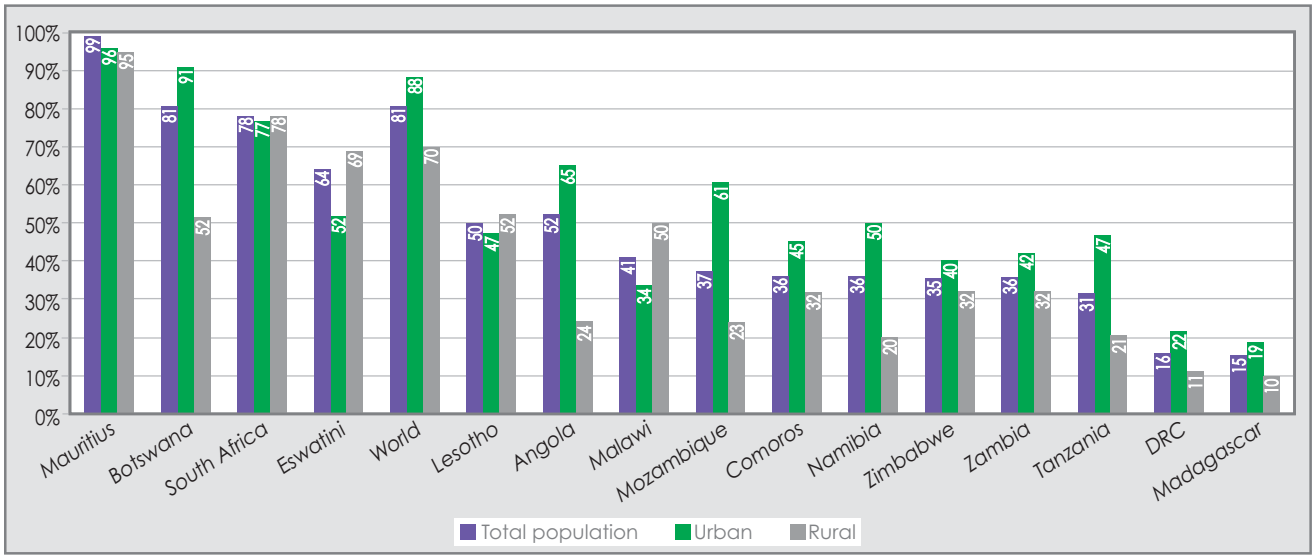
Women walk long distances to collect water in Madagascar. Photo: Zotonantenaina Razanadratefa

[37] UNICEF, Sanitation and hygiene. Available at: https://www.unicef.org/esa/sanitation-and-hygiene, accessed: 12 February 2025.
[38] House, S., Suzanne Ferron, Marni Sommer and Sue Cavill (2014) Violence, Gender & WASH: A practitioner's toolkit. Making water, sanitation and hygiene safer through improved programming and services, SHARE Consortium, http://violence-wash.lboro.ac.uk/

# Access to basic sanitation

There has been progress in expanding access to Water, Sanitation, and Hygiene (WASH) services across the region, yet this advancement has been slow and uneven in many countries. Although the available data does not break down access by sex, data highlights a significant disparity between urban and rural areas. In rural communities, women are typically the primary caretakers responsible for sourcing and delivering water for their households, underscoring their critical role in managing essential resources.

Figure 2.1: Proportion using at least basic sanitation services - % population/urban/rural




*Source: World Bank country data.*[39]

Figure 2.1 illustrates the percentage of the population with access to at least basic sanitation services across the SADC region. Mauritius has almost universal coverage, while Madagascar has the lowest coverage with just 15% of the population having access to basic sanitation services.

The figure reveals a significant gap in access between urban and rural populations, with most countries exhibiting lower coverage in rural areas. However, rural residents in Lesotho, Eswatini, Malawi, and South Africa enjoy higher coverage than their urban counterparts. In nine nations (Malawi, Mozambique, Comoros, Namibia, Zimbabwe, Zambia, Tanzania, Madagascar and DRC), fewer than half of the population have access to at least basic sanitation.

# Access to hygiene

Access to basic hygiene, including proper hand washing and effective sanitation, is crucial for preventing disease transmission and enhancing overall health.

[39] World bank country data, accessed 2 February 2024

Infections account for approximately 25% of the 2.8 million deaths that occur among new-borns globally each year. Over 95% of neonatal deaths caused by sepsis occur in low- and middle-income countries. Promoting good hand hygiene is an affordable and effective strategy to prevent infections in infants, making it a viable intervention in low- and middle-income settings. Enhancing hand hygiene practices could considerably lower infection rates and associated neonatal mortality.

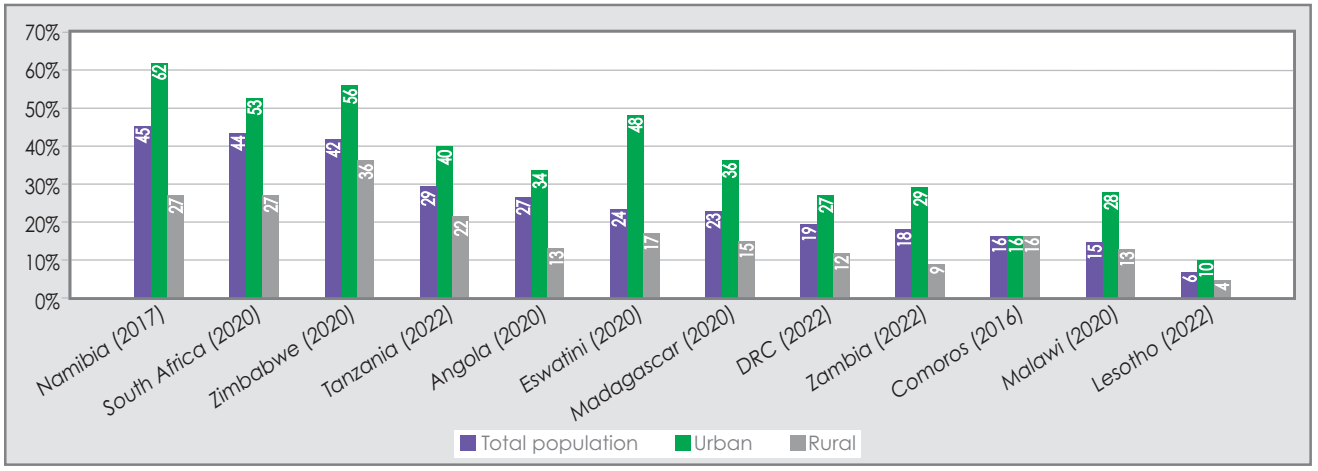
## Barriers to access

- **Lack of resources**: Developing nations may lack the financial resources to invest in water treatment plants and sanitation facilities.
- **Lack of knowledge**: People may not know how to practice good hygiene or believe their actions make a difference.
- **Lack of facilities**: People may not have access to clean water or handwashing facilities.[40]

Progress towards the SDG target on hygiene is monitored through indicator 6.2.1b, which measures the proportion of the population with handwashing facilities and soap and water at home.

Data on access to basic handwashing facilities at home have only been recorded since 2010, and they are not available for all countries or years. The data indicate that progress has been exceptionally slow, and coverage remains low. Similar to access to sanitation, there are significant gaps between urban and rural areas in most countries.

Figure 2.2: Proportion (%) of population with basic handwashing at home in SADC




*Source: World Health Organisation[41]*

Figure 2.2 shows the percentage of the population in the SADC countries that has access to basic handwashing facilities at home. In all SADC countries, fewer than half of the population has access to these facilities. Namibia has the highest coverage (45%) and Lesotho the lowest (6%). The data highlights a significant disparity in access between urban and rural populations; all countries, except Comoros, demonstrate lower coverage in rural areas.

[40] UNICEF, accessed 5 February 2025
[41] World Health Organisation, accessed 4 February 2025

# Family planning (FP)

**SDG 3.7**: By 2030, ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.

**CEDAW: Article 14 (b)**: To have access to adequate health care facilities, including information, counselling and services in family planning.

## Access to contraception

Access to voluntary family planning and reproductive health (FP/RH) services is essential for promoting safe motherhood and fostering healthy families. These services empower individuals and couples by providing them with a variety of modern contraceptive options, enabling them to make informed decisions about their reproductive health. With the ability to plan and space births effectively, couples can better prepare for parenting, ensuring that they have the necessary emotional and financial resources to nurture and support their children. This access not only contributes to the well-being of families but also enhances the overall health and prosperity of communities, helping to reduce maternal and infant mortality rates and improve quality of life for all.

Contraception is essential for women aiming to prevent unplanned or unwanted pregnancies. Access to contraceptives enhances maternal health and increases child survival rates. It also reduces the overall number of abortions, especially unsafe ones. Furthermore, contraception empowers women and supports social and economic development and security.



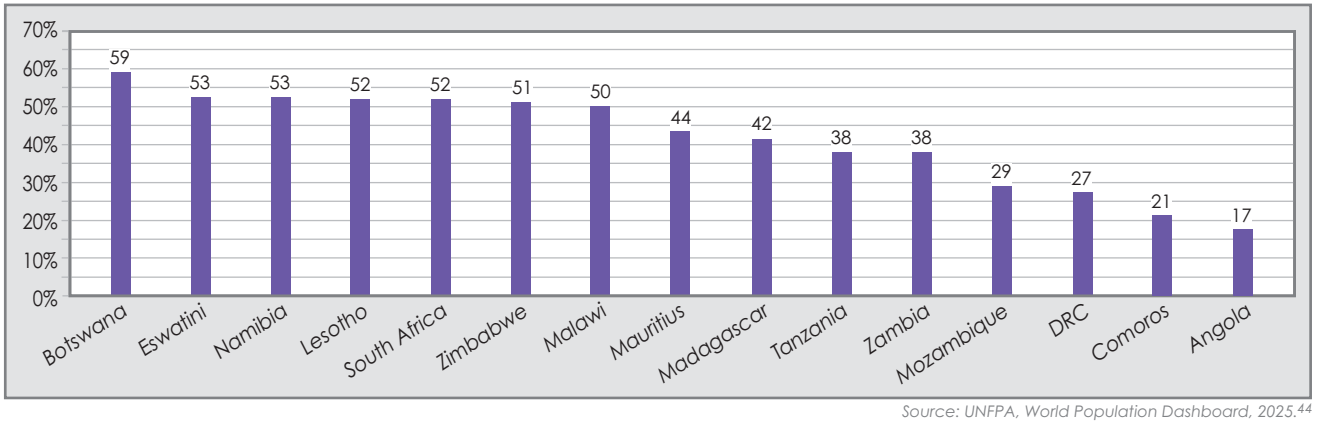

Explanation of contraception - Basic Health Center in Tsaralalana, Madagascar.
Photo: Zotonantenaina Razanadratefa

## Contraceptive prevalence rates (CPR)

Contraceptive prevalence rate in this report refers to the percentage of all women[42] of reproductive age (15-49) who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used.[43]

[42] This is often reported for married/in union women only, which is how we have reported on it previously. In this report we use the broader definition, which includes all women of reproductive age using any method of contraception.
[43] WHO, Sexual and Reproductive Health, https://www.who.int/reproductivehealth/topics/family_planning/contraceptive_prevalence/en/ accessed 4 February 2025

Figure 2.3: Contraceptive prevalence rate (%) amongst all women aged 15-49 any method




*Source: UNFPA, World Population Dashboard, 2025.*[44]

Figure 2.3 shows that the CPR in the SADC region ranges from 59% in Botswana to a low of 17% in Angola. Seven countries (Botswana, Eswatini, Lesotho, Namibia, Malawi, South Africa and Zimbabwe) meet or exceed the global average of 49%.

## *Unmet contraception need*

Women with unmet need for family planning are those who are sexually active but not using any form of contraception. They express a desire to avoid having more children or to delay their subsequent pregnancy. This unmet need highlights the disparity between women's intentions to prevent pregnancy and their actual contraceptive practices.

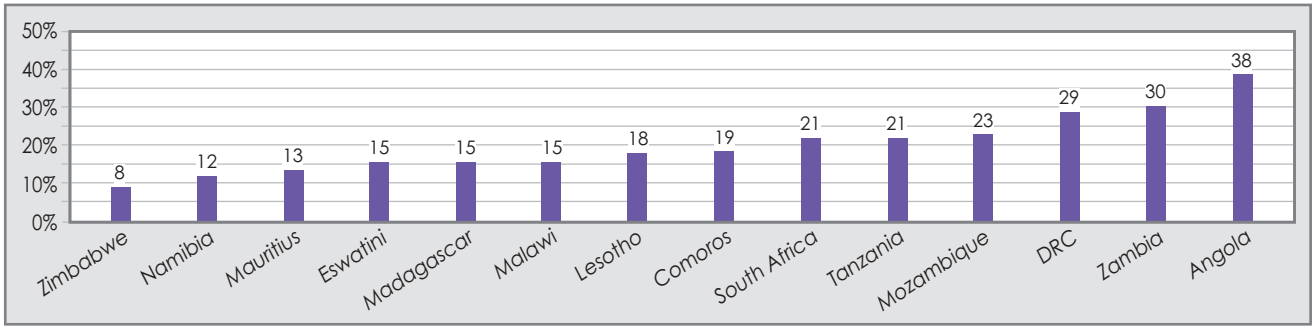
Among the various forms of contraception available, not all are appropriate for every situation. The most suitable contraceptive method is influenced by multiple factors, including a person's overall health, age, frequency of sexual activity, number of sexual partners, future reproductive aspirations, and family history of specific health issues. Providing everyone with access to their preferred contraceptive options upholds several human rights, such as the right to life and liberty, the ability to voice opinions and make decisions, and the right to work and receive an education. Furthermore, this access generates significant health and societal advantages.[45]

More than one out of every ten married women worldwide and one out of every 23 women in sub-Saharan Africa have unmet family planning needs. Despite this, studies concerning sub-Saharan Africa and the community-level factors that may influence the unmet need for family planning are scarce.[46] One study, conducted using data from between 2015 and 2020, assessed factors associated with the unmet need for family planning in sub-Saharan Africa.[47]

The study identified individual and community factors. "Women's age, education, age at cohabitation, heard about family planning through media, parity, number of under-five children, and knowledge about modern contraceptive methods were among the individual-level factors that were associated with both the unmet need for spacing and limiting. Place of residence, community level of women illiteracy (the proportion of women with no formal education), and region were among the community-level factors associated with unmet needs for spacing and limiting. Household size and visiting the health facility in the last 12 months were associated with unmet need for spacing only and husband education was associated with unmet need for limiting only."[48]

[44] UNFPA, World Population Dashboard, accessed 2 February 2025
[45] World Health Organisation, accessed 2 February 2025
[46] Teshale AB (2022) Factors associated with unmet need for family planning in sub-Saharan Africa: A multilevel multinomial logistic regression analysis. PLOS ONE 17(2): e0263885. https://doi.org/10.1371/journal.pone.0263885, accessed 2 February 2025
[47] Ibid
[48] Ibid

Figure 2.4: Unmet need for family planning rate (%) all women aged 15-49




*Source: SADC SRHR scorecard, 2021.*[49]

Figure 2.4 shows the proportion of women who have unmet needs for contraception. Angola has the highest unmet need with 38% of women of reproductive age (15-49 years) having a need for family planning not met. Only Zimbabwe's rate is below the global average of 10%.

There is a correlation between low CPR and high unmet need for contraception. Five countries with the lowest CPR (Angola, DRC, Mozambique, Tanzania and Zambia) also have the highest proportion of women with an unmet need for contraception.

As we further discuss family planning matters, it is essential to mention the FP2030.

## FP2030

FP2030, established in 2021, is the only global partnership focused on family planning (FP). This singular focus unites a wide range of partners across disciplines and sectors, putting family planning at the centre of global health, development, and gender equality.[50]

FP2030 has seven key priorities to improve access to FP:

1. Advance recognition of family planning by expanding partnerships and leveraging the 2030 agenda, leveraging their global network of family planning advocates while building bridges to movements advancing other 2030 goals such as maternal health, universal health care, and climate change, to broaden our impact.
2. Promote increased, diversified, and efficient use of sexual and reproductive health financing to ensure sustainability. Increase financing for family planning by engaging with both traditional and non-traditional funding sources, from national governments to the private sector to high-net-worth individuals.
3. Prioritise the rights of adolescents and youth and of marginalised and stigmatised groups to improve their sexual and reproductive health outcomes. Foster partnerships that elicit and value these voices, as they are the best experts in building programmes that work for them.
4. Support scale-up of evidence-based practices to accelerate impact. FP2030 has taken over coordination of the High Impact Practices for Family Planning, working to gather the best evidence for what works to increase the use of voluntary, rights-based family planning. Promote the use of these evidence-based, scalable, and sustainable approaches to increase contraceptive use in a wide variety of settings and with diverse groups of people.

[49] SADC SHR scorecard, accessed 2 February 2025
[50] https://www.fp2030.org/ accessed 2 February 2025

5. Resource local actors to solve local issues *(cross-cutting priority)*. Sustain and intensify support to local women- and youth-led organisations, and foster movement-building across communities, countries, and regions.
6. Leverage and expand the use of data for evidence-informed decision-making *(cross-cutting priority)*. Continue to collect and share data related to family planning, increasing scope to explore the use of qualitative evidence. Seek new, better indicators to gauge the needs of vulnerable, marginalised, and underserved groups.
7. Improve the performance of our people, systems, and processes to drive results *(cross-cutting priority)*. Invest in resources and tools.

# Female decision-making on SRHR




**SDG Indicator 5.6.1:** Proportion of women, aged 15-49 years, who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.

The rights of women to make informed decisions about their own bodies is a fundamental aspect of achieving gender equality and ensuring universal access to sexual and reproductive health and rights. This right is crucial with three key areas significantly impacting women's empowerment and autonomy.

Firstly, access to reproductive health care services is essential for women to manage their reproductive health effectively. This includes a wide range of healthcare services, such as access to prenatal care; to safe childbirth options; to postnatal care, and access to safe abortion services when necessary. When women can seek and obtain these services without barriers, they are better equipped to make choices regarding their bodies and futures.

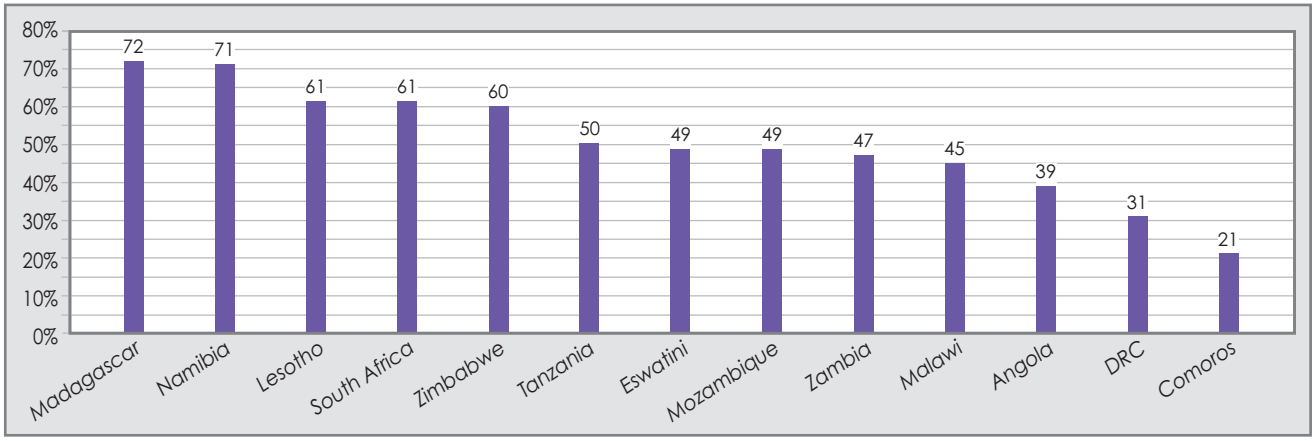
Secondly, the ability to utilise contraceptives plays a vital role in empowering women to control their reproductive lives. This encompasses not only access to a variety of contraceptive methods but also education about their options, the ability to make informed choices, and the right to use contraceptives free from stigma or coercion. Effective contraceptive use allows women to decide if and when to have children, thereby contributing to their overall health and socioeconomic stability.

Lastly, the importance of consensual sexual relations cannot be overstated. Women must have the right to engage in sexual activity based on their own desires and consent, free from pressure or coercion. This also includes the right to say no, seek safe and pleasurable sexual experiences, and discuss matters of sexual health openly with partners.

Together, these three areas - access to reproductive health care, contraceptive use, and consensual relations - form the cornerstones of reproductive rights. Empowering women in these aspects not only furthers individual agency but also strengthens collective societal progress toward gender equality.

The rights of women to make informed decisions about their own bodies is a fundamental aspect of achieving gender equality and ensuring universal access to SRHR

Figure 2.5: Female decision-making on SRHR (%)




*Source: UNFPA, World Population Dashboard, 2007-2022.*[51]

Figure 2.5 shows that there is no country in which all women have control over decision-making on SRHR. Only five countries are above the global average of 57% and eight are below the average for East and Southern Africa of 52%.

Madagascar has the highest proportion of women involved in decision-making on SRHR at 72%, followed by Namibia (71%), South Africa (61%), Lesotho (61%) and Zimbabwe (60%).

# Maternal health

State parties shall, in line with the **SADC Protocol Article 26(a)** and other regional and international commitments by member states on issues relating to health, adopt and implement legislative frameworks, policies, programmes and services to enhance gender-sensitive, appropriate and affordable quality health care, in particular, to:

**SDG 3.1**: By 2030, Reduce maternal mortality to fewer than 70 deaths per 100 000 live births.

**Maputo Protocol Article 14.1**: Ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

a) The right to control their fertility;

b) The right to decide whether to have children, the number of children and the spacing of children; and

c) The right to choose any method of contraception.

Maternal health refers to women's health during pregnancy, childbirth and postpartum. Each stage should be a positive experience, ensuring women and their babies reach their full potential for health and well-being.

[51] https://www.unfpa.org/data/world-population-dashboard Accessed 4 February 2025

# Maternal mortality

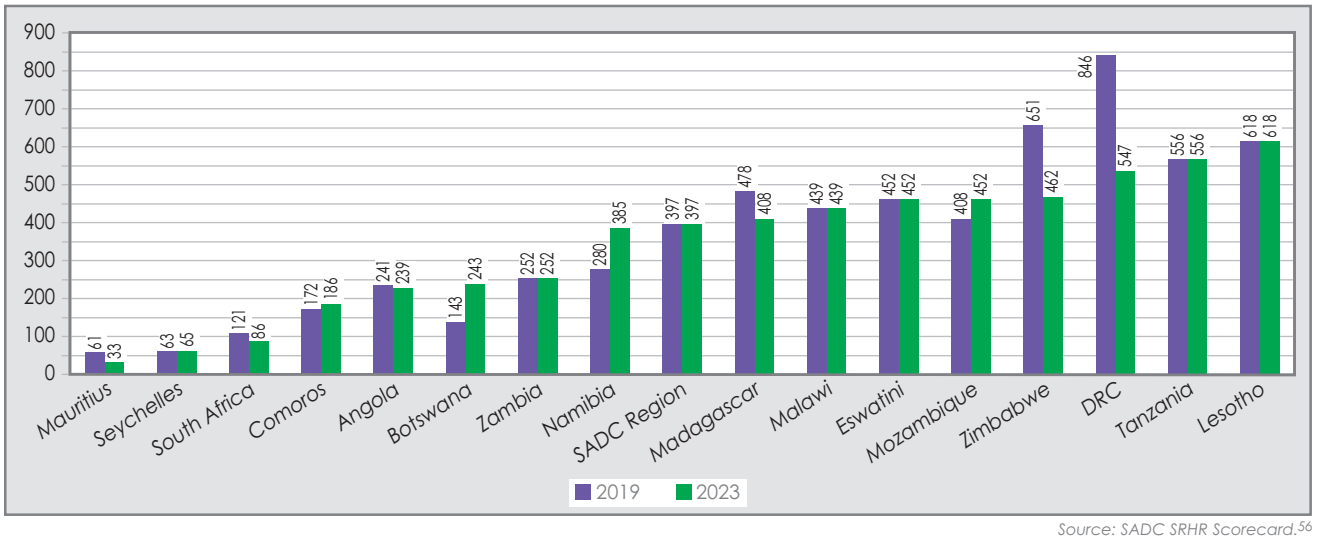
Maternal mortality pertains to fatalities resulting from complications related to pregnancy or child-birth. A significant number of maternal deaths can be avoided with prompt intervention by a qualified healthcare provider in a conducive setting. The principal direct factors leading to maternal harm and death include: severe blood loss, infections, elevated blood pressure, HIV, unsafe abortion practices, and obstructed labour, alongside indirect factors such as anaemia, malaria, and cardiovascular disease.[52]

There has been a significant decrease in maternal deaths worldwide over the last twenty years. The global maternal mortality rate (MMR) dropped from 339 deaths per 100,000 live births in 2000 to 223 deaths per 100,000 live births in 2020.[53] Low-income countries have a significantly higher MMR (462 per 100,000) compared to 11 per 100,000 in high-income countries. In Sub Saharan Africa, the MMR decreased from 802 in 2000 to 536 in 2020.[54]

Most countries in the SADC region are still far from reaching SDG target 3.1 by 2030. A range of factors contribute to this, including the high unmet need for contraception, early and unintended pregnancies, poor access to maternal health services and the standard of care, and socio-economic and demographic factors such as geographical location, poverty, age, and gender inequality.

Assessment of data on deaths in women aged 20 4o 49 in three sites that are analysing longitudinal population based HIV and AIDS data has shown that even in an era of widely available access to ART, there is increased risk of direct maternal mortality in women living with HIV than in women that are not living with HIV. The three sites are Karonga in Malawi, Kisesa in Tanzania and uMkhanyakude in KwaZulu Natal, South Africa. The study estimated that HIV-infected women have 5.2 times the rate of direct maternal mortality compared with HIV-uninfected women (95% CI 2.9-9.5). It concluded that there is a need to improve access to quality maternity care for women living with HIV.[55] This is very critical for many countries in SADC which still have very high HIV prevalence.

Figure 2.6: Maternal Mortality ratio per 100,000 live births 2019 2023




*Source: SADC SRHR Scorecard.*[56]

[52] Ibid
[53] UNICEF maternal mortality database https://data.unicef.org/topic/maternal-health/maternal-mortality/ accessed 15 February 2025
[54] The Conversation, accessed 12 February 2025 https://theconversation.com/most-maternal-deaths-are-preventable-how-to-improve-outcomes-in-south-africa-181282#
[55] Calvert, C. et al, Direct maternal deaths attributable to HIV in the era of antiretroviral therapy: evidence from three population-based HIV cohorts with verbal autopsy. AIDS 34(9):p 1397-1405, July 15, 2020. | DOI: 10.1097/QAD.0000000000002552, https://journals.lww.com/aidsonline/fulltext/2020/07150/direct_maternal_deaths_attributable_to_hiv_in_the.13.aspx accessed 21 February, 2025.
[56] SADC SHR scorecard, accessed 2 February 2025

Figure 2.6 shows uneven progress in reducing maternal deaths in SADC between the baseline SADC SRHR scorecard in 2019 and the second milestone 2023. Maternal mortality remains high in SADC. The regional average has remained static at 397 deaths per 100,000 deliveries. Just two of 16 SADC countries, Seychelles and Mauritius, have met the SDG target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100,000 live births. Maternal mortality decreased in South Africa, Angola, Madagascar, DRC and Zimbabwe but increased in Mauritius, Comoros, Botswana, Namibia and Mozambique. Overall, maternal mortality remains a significant concern in the region. Lesotho is the country with the highest MMR of 618 deaths per 100 000 live births.

## Impact of climate change on maternal and neonatal mortality

Climate change poses a significant and fundamental threat to human health, particularly impacting vulnerable populations such as pregnant women and new-borns who are more susceptible to its adverse effects.

In 2023, using a systematic search strategy based on the concepts of 'climate/air pollution hazards' 'maternal health' and new-born health, researchers sought to identify published systematic and scoping reviews investigating the impact of different climate hazards. The study sought to thoroughly examine and synthesise the existing epidemiological evidence regarding the primary climate-related risks that affect maternal and new-born health (MNH). The focus included exploring how rising temperatures, extreme weather events, and shifting environmental conditions linked to climate change can influence pregnancy outcomes, maternal wellbeing, and the health of new-borns.[57]



Climate change hazards impact food production of small holding farmers' crops in Limpopo, South Africa. Credit: Sandiswa Manana

[57] Conway F, Portela A, Filippi V, Chou D, Kovats S. Climate change, air pollution and maternal and newborn health: An overview of reviews of health outcomes. J Glob Health 2024;14:04128

Table 2.4: Overview of identified MNH outcomes, categorised by climate hazard

| Category of hazard | Associated maternal health outcomes | Associated foetal and peri-natal health outcomes | Associated new-born health outcomes |
|---|---|---|---|
| High temperatures | Hypertensive disorders of pregnancy | Miscarriage | Low birth weight |
| | Gestational diabetes | Stillbirth | Small-for-gestational age |
| | Mental health | Congenital anomalies | Hospitalisation, morbidity, mortality |
| | Access to health services | Preterm birth | Sudden infant death syndrome |
| Ambient air pollution | Hypertensive disorders of pregnancy | Miscarriage | Low birth weight |
| | Gestational diabetes | Stillbirth | Small-for-gestational age |
| | Mental health | Congenital restriction and anomalies | Hospitalisation, morbidity, mortality |
| Disasters (hydro-meteorological) | Access to health services | Preterm birth | Sudden infant death syndrome |
| | Mental health, mortality | Miscarriage | Low birth weight |
| | | Preterm birth | Mortality and morbidity later in life |
| | | Mortality | |
| Water quality and accessibility | Hypertensive disorders of pregnancy | Not documented | Not documented |

*Source: Journal of Global Health.*[58]

This review offers an initial overview of the risks climate change poses to maternal, perinatal, and new-born health, emphasising how the climate crisis could jeopardise recent advances in reducing maternal and new-born mortality and morbidity.

The study notes a pressing need to bolster the evidence base through primary research, primarily by increasing studies from low- and middle-income countries and improving review methodologies to address MNH and climate epidemiology requirements.

Additionally, there is a significant shortage of evidence concerning specific climate hazards and numerous maternal, perinatal, and new-born outcomes. Nevertheless, multiple studies consistently indicate links between the effects of heat and air pollution on birth outcomes, especially preterm births. It is crucial now for policymakers to take action and ensure funding addresses the specific needs of MNH in the context of climate change hazards.

## *Access to maternal health services*

The World Health Organisation (WHO) now recommends that pregnant women have at least eight antenatal care (ANC) contacts with healthcare providers throughout their pregnancy.

This updated guideline aims to improve maternal and foetal health outcomes by increasing the frequency of interactions between pregnant women and healthcare professionals.[59]

[58] Ibid
[59] World Health Organisation, accessed 5 February 2025

Table 2.5: Provision of antenatal and postnatal care

| Country | ANC: at least one visit | | | ANC: at least four visits | | | % women (age 15-49) who received postnatal care within 2 days after birth | | |
|---|---|---|---|---|---|---|---|---|---|
| | National | Rural | Urban | National | Rural | Urban | National | Rural | Urban |
| Angola | 82 | 63 | 92 | 61 | 39 | 74 | 23 | 12 | 31 |
| Botswana | 94 | 94 | 94 | 73 | 70 | 76 | | | |
| DRC | 82 | 77 | 90 | | | | | | |
| Comoros | 95 | 93 | 97 | 64 | 63 | 68 | 91 | 90 | 92 |
| Eswatini | 99 | 99 | 99 | 74 | 73 | 76 | 88 | 85 | 94 |
| Lesotho | 91 | 91 | 92 | 77 | 74 | 80 | 84 | 82 | 87 |
| Madagascar | 89 | 88 | 96 | 60 | 57 | 74 | 55 | 52 | 69 |
| Mozambique | 87 | 83 | 97 | 49 | 41 | 68 | 36 | 33 | 43 |
| Malawi | 97 | 97 | 99 | 51 | 49 | 59 | 84 | 83 | 91 |
| Namibia | 97 | 97 | 97 | 63 | 61 | 64 | 69 | 69 | 69 |
| South Africa | 94 | 96 | 92 | 76 | 80 | 73 | 84 | 81 | 85 |
| Tanzania | 90 | 89 | 92 | 65 | 61 | 76 | 51 | 47 | 60 |
| Zambia | 97 | 96 | 99 | 64 | 65 | 61 | 70 | 64 | 82 |
| Zimbabwe | 93 | 92 | 96 | 72 | 73 | 68 | 82 | 78 | 91 |

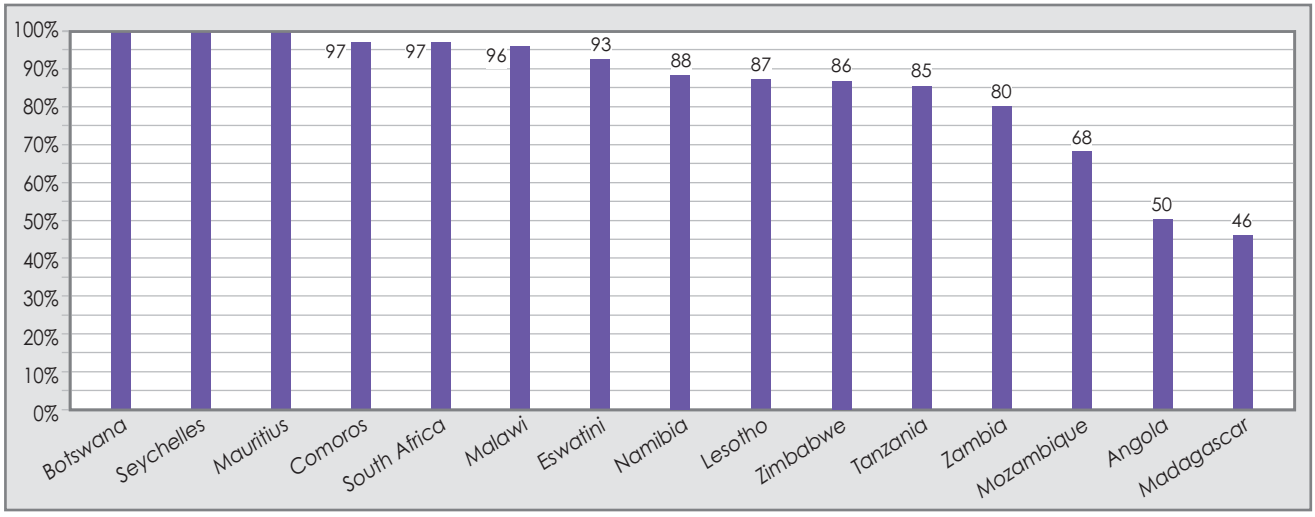
*Source: Maternal and New-born Health Coverage Database updated November 2024*

Table 2.5 shows that no country in the region has all women attended to at least once during pregnancy by skilled health personnel. Angola and DRC have the lowest proportion having at least one visit to a skilled health worker, with just 82% of pregnant women having access to this service. Eswatini has the highest proportion of women attending at least one visit, with close to full coverage for both rural and urban women.

A much lower proportion of women have at least four antenatal visits. However, in five countries (Botswana, Lesotho, Eswatini, South Africa, and Zimbabwe), over 70% of pregnant women have at least four antenatal visits. The table illustrates that the urban/rural divide is significant in almost all countries, partly due to the distances pregnant women have to travel to access clinics.

The proportion of women (age 15-49) who received postnatal care (PNC) within two days after birth is low, with no country achieving 100% coverage. Coverage of these services ranges from 23% in Angola to 90% in Comoros. In two countries (Angola and Mozambique) less than half the women who have given birth receive postnatal care within two days of giving birth.

Figure 2.7: Births delivered by skilled health personnel (%)




*Source: Maternal and New-born Health Coverage Database updated November 2024.*[80]

[60] https://data.unicef.org/topic/maternal-health/newborn-care/ , accessed 5 February 2025

Figure 2.7 illustrates the disparities in access to skilled birth attendants during delivery across SADC countries. Mauritius, Seychelles and Botswana stand out as the only nations where every woman has guaranteed access to qualified healthcare professionals during childbirth. In stark contrast, Angola and Madagascar face significant challenges in maternal healthcare, with alarmingly low percentages of pregnant women receiving assistance from skilled attendants during delivery. Specifically, only 50% of women in Angola and a mere 46% in Madagascar have access to such vital support, highlighting critical gaps in healthcare services that could impact maternal and infant health outcomes.

In many communities, cultural beliefs significantly influence the uptake of these services. For instance, some cultures hold the belief that pregnancy should remain confidential until a particular stage to protect the mother and unborn child from potential harm, such as witchcraft, from surrounding families and communities. This fear often leads to pregnant women delaying or avoiding antenatal clinic visits, despite the known benefits of regular ANC.[61] Adolescent mothers and those with an unwanted or unplanned pregnancy, who may not even realise that they are pregnant, are also at risk of delayed antenatal care.

The WHO's guidelines emphasise the importance of early and regular antenatal care to detect and manage potential complications, provide nutritional and health advice, and ensure a positive pregnancy experience. The first contact is recommended within the first 12 weeks of gestation, followed by subsequent contacts at 20, 26, 30, 34, 36, 38, and 40 weeks. Increased ANC visits are associated with a reduced likelihood of stillbirths and other complications.[62]

Addressing cultural barriers and promoting the benefits of antenatal care through community engagement and education can help improve adherence to these guidelines, ensuring better health outcomes for both mothers and their babies.

# Neonatal mortality

**SDG Target 3.2:** By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

Neonatal mortality refers to the number of deaths during the first 28 days of life per 1000 live births in a given year or period.[63] About a third of all neonatal deaths occur within the first day after birth, and close to three-quarters occur within the first week of life.[64]

The leading causes of neonatal mortality include:

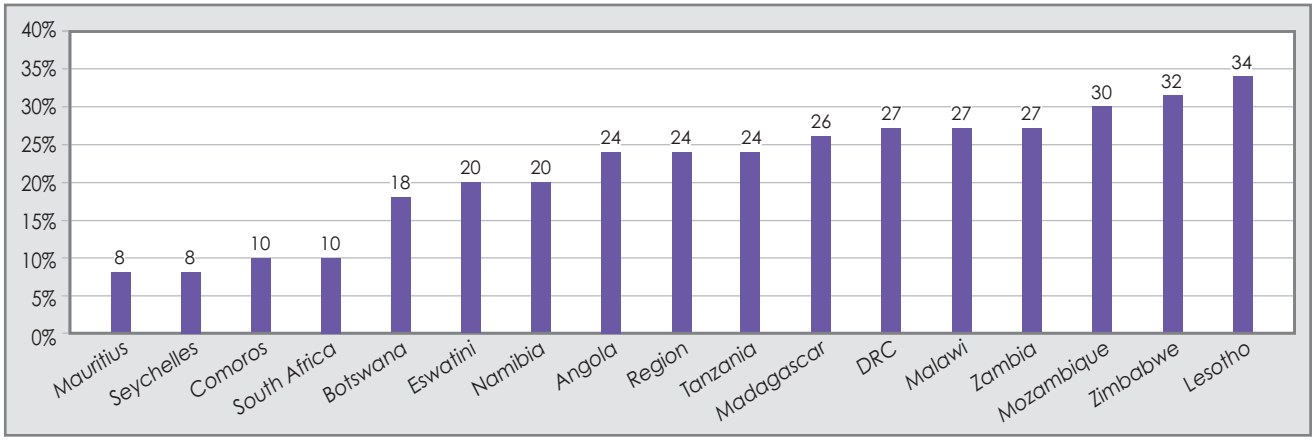
- *Preterm Birth* - Babies born before 37 weeks of gestation often face complications due to underdeveloped organs, especially the lungs, leading to respiratory issues.
- *Birth Asphyxia* - A lack of oxygen during delivery can result in serious complications, causing damage to vital organs and potentially leading to death.
- *Infections* - Neonates are particularly vulnerable to infections such as sepsis, pneumonia, and meningitis, which can be life-threatening if not treated promptly.

[61] Ibid
[62] Ibid
[63] https://www.who.int/whosis/whostat2006NeonatalMortalityRate.pdf , accessed 5 February 2025
[64] https://data.unicef.org/topic/child-survival/neonatal-mortality/ , accessed 5 February 2025

- *Congenital Anomalies* - Birth defects or genetic disorders can affect the baby's health significantly, leading to mortality either immediately after birth or within the neonatal period.
- *Low Birth Weight* - Babies weighing less than 2,500 grams at birth are at increased risk for various complications that can contribute to death.
- *Complications of Maternal Health* - Conditions such as hypertension, diabetes, and infections in pregnant women can impact foetal health and increase the risk of neonatal mortality.
- Inadequate Access to Healthcare - Lack of skilled birth attendants, prenatal care, and neonatal care facilities can contribute significantly to higher neonatal mortality rates.[65]

Efforts to improve maternal healthcare, access to quality neonatal care, and addressing the social determinants of health play crucial roles in reducing neonatal mortality rates globally.

Figure 2.8: Neonatal mortality rate per 1000 live births




*Source: SADC SRHR Scorecard.*[66]

The regional average for neonatal deaths is 24 per 1000, up from 23 in 2019. Figure 2.8 shows that four SADC countries SADC countries (Seychelles. Mauritius, Comoros and South Africa) have achieved the SDG target 3.2 of 12 deaths per 1,000 live births. Lesotho has the highest neonatal mortality rate of 34 deaths per 1,000 live births.

# Reproductive cancers

## Human papillomavirus (HPV) and Cervical cancer (CC)

Cervical cancer (CC), primarily caused by oncogenic types of human papillomavirus (HPV), is a significant global public health issue, especially in countries that have fragile health systems. It has a long latent period, which creates opportunities for early detection through effective screening. Currently, cervical cancer is the fourth most common preventable disease among women, with about 569,847 new cases annually, and it comprises 7.9% of all female cancer cases.

[65] World Health Organisation, accessed 5 February 2025
[66] SADC SHR scorecard, accessed 2 February 2025

Sub-Saharan Africa is particularly affected, accounting for approximately 80% of late-stage cases, with a morbidity rate of 35 new cases and mortality of 23 deaths per 100,000 women per year. Cervical cancer is a leading cause of death in resource-constrained countries, responsible for 311,000 deaths per year, with projections indicating a 42% increase in fatalities by 2030 if stronger prevention strategies are not implemented.

**Human papillomavirus (HPV)** is the most common sexually transmissible infection (STI). In their lifetime, sexually active women and men will be infected at least once without necessarily developing any pathologies. HPV infection is now a well-established cause of cervical cancer. There is growing evidence of HPV being a relevant factor in other ano-genital cancers (anus, vulva, vagina and penis) as well as head and neck cancers. More than 42 million people globally are currently infected with HPV types that cause disease.[67]

Risk factors for HPV include a history of tobacco use, lack of condom use at high-risk sex and HIV infection. Male circumcision and the use of condoms have shown a significant protective effect against HPV transmission.

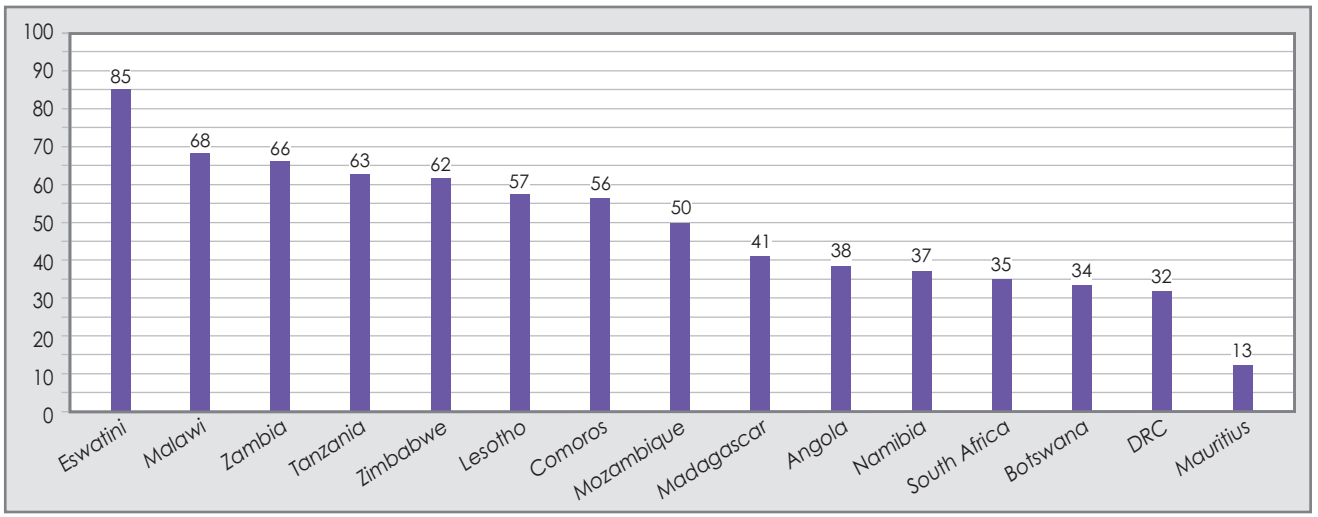
HPV types 16 and 18 are responsible for about 70% of all cervical cancer cases worldwide. HPV vaccines that prevent HPV 16 and 18 infections are now available and have the potential to reduce the incidence of cervical and other ano-genital cancers.[68]

In May 2018, the WHO launched a Global Initiative to scale up preventive, screening, and treatment interventions to eliminate cervical cancer as a public health challenge in the 21st century. WHO Cervical Cancer Elimination Strategy Targets for 2030 include:

- 90% of girls fully vaccinated with the HPV vaccine by the age of 15.
- 70% of women are screened with a high-performance test by 35 years of age and again by 45 years of age.
- 90% of women identified with cervical disease receive treatment.[69]

Cervical cancer is a leading cause of death in resource-constrained countries, responsible for 311,000 deaths per year

Figure 2.9: Incidence of cervical cancer due to HPV in SADC (2020 estimates)




*Source HPV information centre.*[70]

[67] https://www.cdc.gov/hpv/parents/about-hpv.html , accessed 5 February 2025
[68] Ibid
[69] World Health Organisation, accessed 5 February 2025
[70] Bruni L, Albero G, Serrano B, Mena M, Collado JJ, Gómez D, Muñoz J, Bosch FX, de Sanjosé S. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in Africa. Summary Report 10 March 2023.

The incidence of cervical cancer attributable to HPV is extremely high in many SADC countries. Figure 2.9 shows that the prevalence rate of cervical cancer per 100,000 women per year, attributable to HPV is higher than the African average of 26 incidences in all countries except Mauritius. Of the 10 countries in Africa with the highest cervical cancer prevalence rate seven are in SADC (Eswatini, Malawi, Zambia, Tanzania, Lesotho, Comoros and Mozambique). Mauritius is the only country with a prevalence rate equal to the global average of thirteen.

Eight SADC countries rate in the top ten of the incidence of cervical cancer cases attributable to HPV. Effective primary (HPV vaccination) and secondary prevention approaches (screening for, and treating precancerous lesions) will prevent most cervical cancer cases. When diagnosed, cervical cancer is one of the most successfully treatable forms of cancer, as long as it is detected early and managed effectively. However, 84% of new cases occur in low-and-middle income countries due to poor access to all three prevention strategies. Cancers diagnosed in late stages can be controlled with appropriate treatment and palliative care.

## *Primary prevention: HPV Vaccination*

The WHO recommends a two-dose schedule of the HPV vaccine administered 6-12 months apart to girls aged 9-14 years as the primary target for prevention of cervical cancer. WHO has set a target 90% of girls fully vaccinated with the HPV vaccine by the age of 15. One of the recommendations of the WHO is for states to include HPV vaccination as part of the national vaccination programme.[71]

Table 2.6: HPV vaccination programmes

| Country | HPV included in national vaccination programme | Proportion of females who received recommended dose by age 15[72] |
|---|---|---|
| Mauritius | Yes (2016) | 67% |
| Tanzania | Yes (2018) | 65% |
| Lesotho | Yes (2012. Reintroduced 2022) | 64% |
| Seychelles | Yes (2014) | 62% |
| Mozambique | Yes (2021) | 57% |
| Zimbabwe | Yes (2018) | 54% |
| Zambia | Yes (2019) | 39% |
| South Africa | Yes (2014) | 36% |
| Botswana | Yes (2015) | 22% |
| Malawi | Yes (2019) | 13% |
| Eswatini | Yes (2023) | No data |
| Madagascar | No | No data |
| Angola | No | No data |
| Comoros | No | No data |
| DRC | No | No data |
| Namibia | No | No data |

*Source: Asempah, E., Ikpebe, E. Accelerating HPV vaccination in Africa for health equity.[73]*

Table 2.6 shows that eleven countries in SADC have included HPV in their national vaccination programme, though coverage varies across countries. There is a high of 67% in Mauritius and low of 13% in Malawi. These programmes are critical given the high prevalence of cervical

[71] World Health Organisation, accessed 2 February 2025
[72] SADC SRHR Scorecard, accessed 2 February 2025
[73] Asempah, E., Ikpebe, E. Accelerating HPV vaccination in Africa for health equity. glob health res policy 9, 37 (2024). https://doi.org/10.1186/s41256-024-00380-https://ghrp.biomedcentral.com/articles/10.1186/s41256-024-00380-z accessed 20 February, 2025

cancer linked to HPV in the region, aligning with WHO's target to eliminate cervical cancer as a public health issue by 2030 through expanded vaccination, screening, and treatment initiatives.

It is clear from Table 2.6 that quite drastic action is needed to increase vaccination coverage. There have been times when HPV vaccine has not been available. Recommendations that have been made to increase coverage include:[74]

- incentivise vaccine manufacturers to increase production and distribution of the vaccine and make it available, affordable, and accessible to low resourced regions;
- support a regional strategy of vaccine purchasing and distribution to support low-resource countries;
- design culturally tailored community-based interventions to reach marginalised and vulnerable communities with monitoring and evaluation to identify gaps and inequalities in vaccination coverage;
- involve men in immunisation outreach; and
- develop sustainable financing of vaccination through incremental shift to domestic and continental funding sources.

Cervical cancer highlights disparities in health and gender. In 2020, approximately 100,000 women in the African Region were diagnosed with this illness, and nearly 70,000 of them succumbed to it. This accounts for 21% of the global mortality from cervical cancer. Over 50% of the cases in this region occur in women who are HIV-positive, who face a six-fold increase in the likelihood of developing this disease. This situation illustrates the ongoing inequities that result from high HIV prevalence.[75]

## *Secondary prevention: Cervical cancer screening*

A secondary prevention strategy is cervical cancer screening to identify early precancerous lesions.. However, many women, especially those in rural areas, have limited access to and, therefore, utilisation of screening services.

A qualitative synthesis of 60 mixed studies published from 1 January 2013 to mid-2022 examined the drivers, enablers, and detractors of cervical cancer prevention and management in sub-Saharan Africa. Studies were selected following Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines. A thematic analysis was conducted and themes were identified.

The study found that screening and early detection programmes for cervical cancer are shaped by factors at various levels. **Individual-level** factors included insufficient knowledge regarding cervical cancer and screening literacy, along with a low perception of risk, attitudes, susceptibility, fear of test results, and sociodemographic characteristics among women. **Interpersonal** factors involved community embarrassment, relationships between women and health workers, support and encouragement, the presence of peers or relatives to model preventive behaviours, and mothers' connections with others. At the **organisational level**, influential factors were associated with providers, including their cervical cancer screening practices, training, type of profession, counselling skills, gender, recommendations from experts, and work commitments. **Community-level** factors that impacted cervical cancer screening included stigma, social and cultural norms, social networks, and beliefs. Factors at the **system and policy levels** included the absence of nearby facilities, geographic isolation, resource distribution and logistics management, screening costs, promotional policies, ownership and management, lack of a decentralised cancer policy, and inadequate supportive infrastructure.[76]

[74] Ibid
[75] WHO, HPV Vaccination in Africa: A Game-changer for Women's and Girls' Health, CPHIA 2023, accessed 5 February 2025
[76] Atnafu et al., Drivers of cervical cancer prevention and management in sub-Saharan Africa: a qualitative synthesis of mixed studies, Health Research Policy and Systems (2024)

Table 2.7: Screening for cervical cancer

| Country | Crude cervical cancer incidence per 100 000 women | National screening programme exists | Screened ever | Screened in last five years |
|---|---|---|---|---|
| South Africa | 36 | Yes | 52% | 43% |
| Mauritius | 19 | Yes | 42% | 25% |
| Zambia | 35 | Yes | 20% | 17% |
| Malawi | 43 | Yes | 19% | 15% |
| Tanzania | 35 | Yes | 13% | 11% |
| Madagascar | 27 | Yes | 8% | 5% |
| Mozambique | 33 | Yes | 3% | 3% |
| Botswana | 31 | No | 50% | 39% |
| Namibia | 29 | No | 39% | 29% |
| Seychelles | No data | No | 32% | 26% |
| Angola | 19 | No | 25% | 20% |
| DRC | 17 | No | 20% | 18% |
| Zimbabwe | 40 | No | 20% | 19% |
| Eswatini | 58 | Np | 19% | 15% |
| Lesotho | 50 | No | 17% | 14% |
| Comoros | 39 | No | 11% | 9% |

*Source: HPV Information Centre country profiles.*[77]

Table 2.7 shows that seven SADC countries have national cervical cancer screening programmes but coverage is patchy especially in Madagascar and Mozambique where just 8% and 3% of women have ever been screened for cervical cancer.

No country in SADC is near to the WHO target of 70% women are screened with a high-performance test by 35 years of age and again by 45 years of age.

The table shows that in most countries where there is a cancer screening programme, coverage is higher than where there is no programme in place.

# Universal health care (UHC)




**SDG 3.8**: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

According to the WHO "UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course."[78] Sexual and reproductive health services are considered essential and are therefore included in this definition. Protecting people from the financial consequences of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow - destroying their futures and often those of their children.

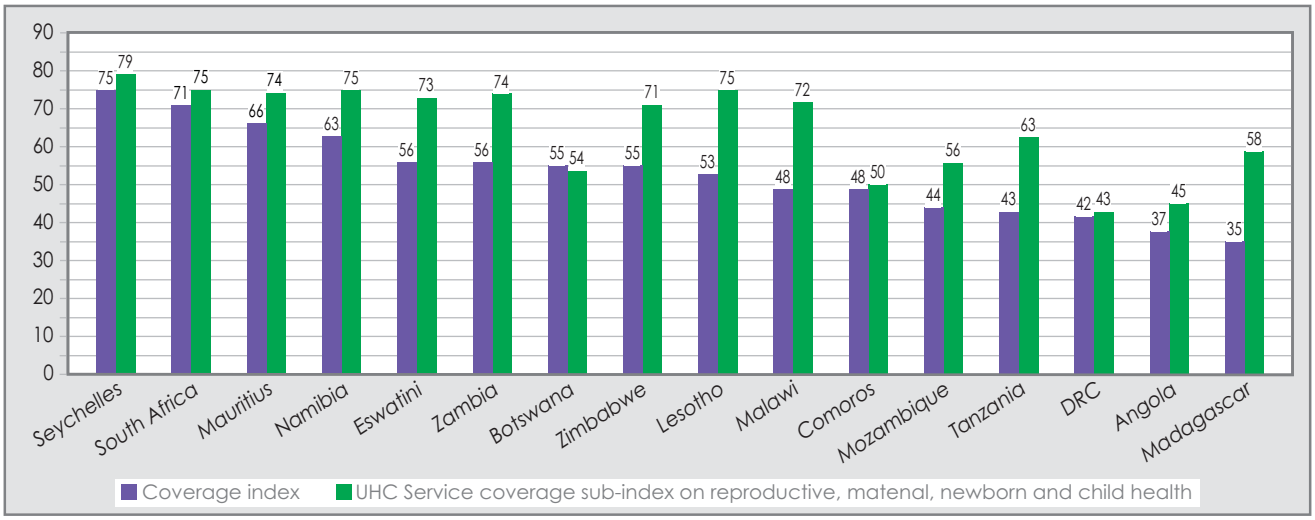
[77] Bruni L, Albero G, Serrano B, Mena M, Collado JJ, Gómez D, Muñoz J, Bosch FX, de Sanjosé S. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in Africa. Summary Report 10 March 2023.
[78] WHO, Fact Sheet: Universal Health Coverage, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) accessed 12 July 2021

Monitoring progress towards UHC should focus on:

- The proportion of a population that can access essential quality health services (SDG 3.8.1).
- The proportion of the population that spends a large amount of household income on health (SDG 3.8.2).

The Universal Health Coverage (UHC) Index is measured on a scale from 0 (worst) to 100 (best) based on the average coverage of essential services including reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access.

Figure 2.10: UHC: Service coverage index and access to reproductive, maternal, new-born and child health services




*Source: World Bank data.*[79]

Figure 2.10 shows that no country in SADC provides universal health care. The universal health coverage index ranges from 75 in Seychelles to 35 in DRC. Only Seychelles and South Africa are above the global average of 67. Mauritius and Namibia have an index of between 60 and 65 while Madagascar, Malawi, Tanzania, Comoros, Mozambique, Angola and DRC are below 50 on the UHC index.

Access to reproductive, maternal, new-born, and child health (RMNCH) services is a component of UHC service coverage. It is higher than the overall coverage in all countries except Botswana. Seychelles (79) South Africa (76) and Lesotho (75) have the highest RMNCH index ratings, while DRC (43) has the lowest.

## Expenditure in the health sector

Health spending encompasses all costs associated with delivering health services, family planning initiatives, nutrition programmes, and emergency health assistance, but does not cover expenses related to drinking water and sanitation.

Health expenditure is an important indicator of a government's commitment to the health and wellbeing of its citizens. Increasing expenditure on health is associated with better health outcomes, especially in low-income countries. When a government commits proportionally less

of its total expenditure on health, this may indicate that health, including nutrition, is not regarded as a priority.

There are two measures to assess health financing: the level of health spending as a proportion of the total government spending and health spending as a proportion of a country's Gross Domestic Product (GDP). The GDP represents the total value of everything produced in the country. It does not matter if citizens or foreigners produce it - if they operate within a country's boundaries, research includes this production in GDP.[80]

Table 2.8 shows that Botswana is the only SADC country that has met, and exceeded the recommended Abuja Declaration goal of 15%, of the state's annual budget to improve the health sector. Seven countries allocate between 10% and 14% of their annual budget on health; seven countries spend between 6% and 10% and two countries spend less than 6% of the annual budget on the health sector. Only Lesotho spends more than 10% of its GDP on health.

Table 2.8: Health financing analysis

| Country | % annual budget allocated to the health sector | Health expenditure as % of GDP |
|---|---|---|
| **Botswana** | **19** | 6 |
| Comoros | 12 | 6 |
| **Lesotho** | 12 | **10** |
| Namibia | 12 | 9 |
| Eswatini | 11 | 7 |
| Zimbabwe | 11 | 3 |
| Malawi | 10 | 7 |
| DRC | 9 | 4 |
| Madagascar | 8 | 4 |
| Mozambique | 8 | 9 |
| South Africa | 8 | 8 |
| Zambia | 8 | 7 |
| Angola | 7 | 3 |
| Tanzania | 7 | 3 |
| Seychelles | 5 | 5 |
| Mauritius | 3 | 6 |

*Source: SADC SRHR Scorecard, WHO Databank.*[81]




Performance event on sexual reproductive health and rights in South Africa. Photo: Gender Links

[80] The Balance, accessed 10 February 2025
[81] SADC SHR scorecard, accessed 2 February 2025

# Next steps

This chapter shows that with just five years to go for states to reach the targets set in the SADC Gender Protocol and the SDGs, SADC states are far behind.

The current global context is characterised by rising nationalism and of the far-right rolling back women's rights, increasing war and conflict and the climate crisis in the context of dwindling support and resources for women's rights work.

Women's rights in general, and SRHR in particular, are under threat. The rise in nationalism has led to tightened borders and restrictions on migration, which can further marginalise women, especially those from minority or immigrant backgrounds. Nationalist rhetoric often promotes traditional gender roles, leading to backlash against women's rights. As nations grapple with identity politics, issues such as reproductive rights and gender equality can become points of contention, risking setbacks in hard-won gains. This also has dire impacts on funding for the global South - shifts to the right in previously progressive countries like the Netherlands and Sweden are resulting in cuts in funding to women's rights organisations in the global South. The intersection of these crises creates a dire situation that threatens women's immediate survival and challenges the long-term advancement of women's rights and gender equality.

This moment requires the women's movement to restrategise to address these challenges.

- **Build alliances** with other progressive organisations and movements facing similar challenges. This enhances advocacy and ensures that well-intentioned actions or messaging do not cause unintended negative consequences.
- **Documenting** opposition helps raise awareness within the broader community, including allies outside the region, about the ongoing struggles faced by LGBTQI+ individuals in SADC. This also encourages public support and solidarity.
- **Collaboration with stakeholders** - such as policymakers, educators, and healthcare providers - is a critical tactic for fostering support and driving meaningful change in the legal landscape.

## Policy and Advocacy

- Lobby to update dated policies in line with international standards on SRHR and the SADC SRHR strategy and scorecard.
- Monitor implementation of frameworks and policies and hold governments accountable.

## Menstrual health

- Lobby governments to scrap VAT on menstrual products and provide free sanitary wear in schools, especially in rural and underprivileged areas.
- Lobby governments to invest more in water, sanitation and hygiene in all settings, including household, communities, schools and health care facilities, with a particular focus on rural areas, where access to these services is substantially lower than in urban areas.
- Work with men, traditional and community leaders to combat period poverty and stigma.

## Maternal health

- Conduct research on the reasons for the persistently high levels of maternal mortality, particularly in the context of increasing war and conflict and climate change.
- Lobby governments to implement programmes to increase access to maternal health services such as antenatal care, skilled birth attendance and neonatal care especially in rural areas.

## Contraception and family planning

- Identify areas and communities where women have a high unmet need for family planning and develop access and provision strategies.

- Lobby governments to subsidise Family Planning Services and Products: Making contraception and family planning services affordable or free helps reduce financial barriers, especially for low-income groups. Governments could subsidize contraceptives, offer free maternal health services, and ensure that high-quality care is accessible to all, particularly in rural areas.

## HPV and cervical cancer

- Lobby governments to include the HPV vaccine in the national vaccination programme; conduct education and awareness programmes on HPV, and step up the rate of vaccination especially in schools.
- Implement the cervical cancer programmes in schools; develop strategies to speed up coverage of screening, including allocating budgets and raising awareness about cervical cancer and how it can be prevented.

## Universal health care coverage

- Lobby governments to invest in and develop partnerships to facilitate roll out of UHC including SRHR services.
- Promote Integrated Healthcare Services: Integrating family planning and maternal health services into primary healthcare allows countries to use existing infrastructure more efficiently. This integration ensures that women can access multiple services in one visit, making it more convenient and reducing costs associated with separate visits.

## Investment and expenditure

- Lobby government to recommit to increasing investment in the health sector to 15% of their annual budget in line with the Abuj Declaration goal.
- Lobby governments to increase budget allocation for family planning and maternal health services by dedicating a higher portion of health budgets to family planning and maternal health, governments can ensure that essential services - such as contraception, prenatal, and postnatal care - are widely available. Evidence shows that targeted investment in these areas leads to lower maternal and infant mortality rates, as well as better health outcomes for women and families.

## Utilise Conditional Cash Transfers

Initiatives that provide financial incentives to women to use maternal healthcare can boost participation. Conditional cash transfers have proven effective in enhancing the use of prenatal and postnatal care and promoting consistent family planning appointments in various low-income areas around the world.

## Leverage Donor and International Funding

Collaborating with global entities like UNFPA, the World Bank, and the Global Financing Facility (GFF) can enable SADC nations to obtain both technical assistance and financial resources for maternal and reproductive health initiatives. These collaborations can offer funding for critical areas, including education on adolescent sexual health, the supply chain for contraceptives, and training programmes focused on maternal health.

## Strengthen Data Collection for Targeted Interventions

Establishing and improving health information systems to collect data on family planning and maternal health helps in planning and resource allocation. Reliable data allows for targeted interventions, ensuring that resources go where they are most needed and can have the greatest impact, such as adolescent reproductive health services or maternal health education in underserved areas.

## Community Engagement and Education

Engaging local communities and traditional leaders in family planning and maternal health initiatives can reduce cultural barriers and promote understanding. Public awareness campaigns focused on the benefits of family planning, safe delivery, and maternal health can shift cultural perceptions and increase service demand, justifying sustained investment in these areas.

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